		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042861

Facility Name: Provena Villa Franciscan

Address: 210 N. Springfield Ave. (Number) Joliet (City) 60435-6598 (Zip Code)

County: Will

Telephone Number: (815)725-3400 **Fax #** (815)725-2160

IDPA ID Number: 37 1127787008

Date of Initial License for Current Owners: 12/01/97

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Denise Nichols **Telephone Number:** (815) 928-6847

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Brent Shear
(Title) VP-Finance Provena Senior Services

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	12	Skilled (SNF)	12	4,380	1
2		Skilled Pediatric (SNF/PED)			2
3	164	Intermediate (ICF)	164	59,860	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	176	TOTALS	176	64,240	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,579	2,664	7,646	11,889	8
9	SNF/PED					9
10	ICF	20,993	24,569		45,562	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,572	27,233	7,646	57,451	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.43%

D. How many bed-hold days during this year were paid by Public Aid?
15 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 09/01/90

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date _____ NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 40 and days of care provided 7,646

Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Provena Villa Franciscan # 0042861 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	287,038	38,897	43,467	369,402		369,402		369,402			1
2	Food Purchase		243,711		243,711		243,711		243,711			2
3	Housekeeping	138,298	27,530		165,828		165,828		165,828			3
4	Laundry	35,231	1,093	186,205	222,529		222,529		222,529			4
5	Heat and Other Utilities			154,035	154,035		154,035		154,035			5
6	Maintenance	129,761	29,091	58,279	217,131		217,131	(85)	217,046			6
7	Other (specify):* Pastoral Care	26,517	844	831	28,192		28,192		28,192			7
8	**TOTAL General Services**	616,845	341,166	442,817	1,400,828		1,400,828	(85)	1,400,743			8
	B. Health Care and Programs											
9	Medical Director			12,180	12,180		12,180		12,180			9
10	Nursing and Medical Records	2,215,222	252,756	872,441	3,340,419		3,340,419		3,340,419			10
10a	Therapy			444,053	444,053		444,053		444,053			10a
11	Activities	120,057	2,844	33,107	156,008		156,008	(30,773)	125,235			11
12	Social Services	36,698	18	1	36,717		36,717		36,717			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,371,977	255,618	1,361,782	3,989,377		3,989,377	(30,773)	3,958,604			16
	C. General Administration											
17	Administrative	72,252		505,300	577,552		577,552	(303,225)	274,327			17
18	Directors Fees											18
19	Professional Services			16,242	16,242		16,242		16,242			19
20	Dues, Fees, Subscriptions & Promotions			34,678	34,678	840	35,518	(9,475)	26,043			20
21	Clerical & General Office Expenses	222,107	9,568	220,664	452,339		452,339	(170,273)	282,066			21
22	Employee Benefits & Payroll Taxes			716,150	716,150	(840)	715,310	55,607	770,917			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,972	6,972		6,972		6,972			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			28,642	28,642		28,642		28,642			26
27	Other (specify):* Fundraising		44	3,486	3,530		3,530	(3,530)				27
28	**TOTAL General Administration**	294,359	9,612	1,532,134	1,836,105		1,836,105	(430,896)	1,405,209			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,283,181	606,396	3,336,733	7,226,310		7,226,310	(461,754)	6,764,556			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Provena Villa Franciscan #0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			359,761	359,761		359,761		359,761			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							203,368	203,368			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			359,761	359,761		359,761	203,368	563,129			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		552,595		552,595		552,595		552,595			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			96,624	96,624		96,624		96,624			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		552,595	96,624	649,219		649,219		649,219			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,283,181	1,158,991	3,793,118	8,235,290		8,235,290	(258,386)	7,976,904			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(195)	21		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(162,031)	21		24
25	Fund Raising, Advertising and Promotional	(9,475)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,530)	27		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (175,231)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(44,250)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,250)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (219,481)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Provena Villa Franciscan

ID# 0042861

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Misc Expense - Activities	$ (30,773)	11	1
2	Misc Expense - Maint.	(85)	6	2
3	Misc Expense - Admin	(8,047)	21	3
4				4
5	Fundraising - Supply Exp	(44)	27	5
6	Fundraising - Misc. Expenses	(3,486)	27	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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37				37
38				38
39				39
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42				42
43				43
44				44
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65				65
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68				68
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70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(42,435)		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(85)	0	0	0	0	0	0	0	0	0	0	(85)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(85)	0	0	0	0	0	0	0	0	0	0	(85)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(30,773)	0	0	0	0	0	0	0	0	0	0	(30,773)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(30,773)	0	0	0	0	0	0	0	0	0	0	(30,773)	16
	C. General Administration													
17	Administrative	0	(303,225)	0	0	0	0	0	0	0	0	0	(303,225)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(9,475)	0	0	0	0	0	0	0	0	0	0	(9,475)	20
21	Clerical & General Office Expenses	(170,273)	0	0	0	0	0	0	0	0	0	0	(170,273)	21
22	Employee Benefits & Payroll Taxes	0	55,607	0	0	0	0	0	0	0	0	0	55,607	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(3,530)	0	0	0	0	0	0	0	0	0	0	(3,530)	27
28	**TOTAL General Administration**	(183,278)	(247,618)	0	0	0	0	0	0	0	0	0	(430,896)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(214,136)	(247,618)	0	0	0	0	0	0	0	0	0	(461,754)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Provena Villa Franciscan # 0042861 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	203,368	0	0	0	0	0	0	0	0	0	203,368	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	203,368	0	0	0	0	0	0	0	0	0	203,368	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(214,136)	(44,250)	0	0	0	0	0	0	0	0	0	(258,386)	45

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Provena Senior Services	100	See attached listing				
Provena Health						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		17	Management Fees	$ 505,300	Provena Senior Services-salary	100.00%	$ 202,075	$ (303,225)	1
2	V		22			-benefit		55,607	55,607	2
3	V		32			-interest expense		203,368	203,368	3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 505,300			$ 461,050	$ * (44,250)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		N/A				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	St. Joseph Med Center	X		Construction Loan	$35,821.55	03/25/91	$ 5,000,000	$ 3,274,509	02/25/11	6.00%	$ 203,368	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,821.55		$ 5,000,000	$ 3,274,509			$ 203,368	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,000,000	$ 3,274,509			$ 203,368	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 70,000 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	2.71 ACRES	1990	$ 285,994	1
2					2
3	TOTALS	#VALUE!		$ 285,994	3

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	176		1990	1990	$ 6,928,569	$ 302,259	5-30	$ 302,259	$	$ 3,280,286	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Hot Water Heater			2000	11,470	574	10	574		574	9
10	Smoke Detector/Dampers/interface with fire alarm system			2000	51,313	4,200	5-7	4,200		4,200	10
11	Common Area Assessment			2000	10,255	740	5-10	740		740	11
12	Conveyor Toaster			2000	590	59	5	59		59	12
13	Relocate Nurse Call System			2000	2,576	258	5	258		258	13
14	Carpet			2000	1,565	157	5	157		157	14
15	Rear Exterior Door			1999	2,930	419	7	419		628	15
16	Bowl Guard			1999	681	136	5	136		204	16
17	Insulated Food Storage Units			1999	1,325	189	7	189		284	17
18											18
19	Electrical repair/replacement			1998	12,410	2,482	5	2,482		6,205	19
20	Wing remodeling			1998	30,166	2,782	10	2,782		7,540	20
21	Fence-Red Cedar			1997	2,400	240	10	240		860	21
22	Sidewalk concrete			1997	3,380	211	20	211		788	22
23	Bushes perennials			1997	2,240	448	10	448		1,381	23
24	Benches 6'			1996	1,585	159	10	159		647	24
25	Film for windows			1996	5,988	1,198	5	1,198		4,142	25
26	Vinyl Sheeting for Hallway			1996	4,100	410	10	410		1,470	26
27	Italia Paper Rubrail Cove (revised life from prior year)			1996	8,047	1,609	5	1,609		5,297	27
28											28
29											29
30											30
31	Adjustment to record estimated depreciation expense recorded										31
32	on financial statements to actual					(54,590)		(54,590)			32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 7,081,590	$ 263,938		$ 263,938	$	$ 3,315,720	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 891,007	$ 88,154	$ 88,154	$	5-15	$ 663,376	37
38	Current Year Purchases	52,138	3,646	3,646		5-15	3,646	38
39	Fully Depreciated Assets	365,014					365,014	39
40								40
41	TOTALS	$ 1,308,159	$ 91,800	$ 91,800	$		$ 1,032,036	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42		1994 Ford	1994	$ 40,249	$ 4,023	$ 4,023	$	10	$ 27,839	42
43										43
44										44
45										45
46	TOTALS			$ 40,249	$ 4,023	$ 4,023	$		$ 27,839	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,715,992	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 359,761	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 359,761	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,375,595	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	None	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	None	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)	N/A			#VALUE!
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$ #VALUE!
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Provena Villa Franciscan # 0042861 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 4,242,543	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 736,223)		9,221,043	3
4	Supply Inventory (priced at Cost)		451,930	4
5	Short-Term Investments			5
6	Prepaid Insurance		18,282	6
7	Other Prepaid Expenses		220,967	7
8	Accounts Receivable (owners or related parties)		110,881	8
9	Other(specify): **This Balance Sheet is for Provena Senior Services		603,895	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 14,869,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		6,504,791	12
13	Land		7,853,836	13
14	Buildings, at Historical Cost		68,287,725	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost		11,695,959	16
17	Accumulated Depreciation (book methods)		(29,770,402)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,199,632	22
23	Other(specify): Goodwill (net)		3,926,223	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 69,697,764	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 84,567,305	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 1,500,710	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits		548,703	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		2,162,467	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)		245,211	32
33	Accrued Interest Payable		19,755	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Current Maturity of LT Debt		340,968	36
37	Due to Related Parties		(70,512)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 4,747,302	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		44,952,248	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Self Ins Liability		104,327	43
44	Other		67,748	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 45,124,323	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 49,871,625	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 34,695,680	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 84,567,305	48

***(See instructions.)**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 32,057,986	1
2	Restatements (describe):		2
3	1999 Audit Adjustments	(27,746)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 32,030,240	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	2,887,291	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,887,291	17
	B. Transfers (Itemize):		
18	Transfers from Home Office	(45,939)	18
19	Unrealized Gain(Loss)	(175,912)	19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (221,851)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 34,695,680	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,685,673	1
2	Discounts and Allowances for all Levels	(40,313)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,645,360	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	912,933	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 912,933	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	39,135	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	562,431	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	4,430	20
21	Other Medical Services		21
22	Laundry	31,137	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 637,133	23
	D. Non-Operating Revenue		
24	Contributions	1,030	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,030	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,196,456	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,400,828	31
32	Health Care	3,989,377	32
33	General Administration	1,836,105	33
	B. Capital Expense		
34	Ownership	359,761	34
	C. Ancillary Expense		
35	Special Cost Centers	552,595	35
36	Provider Participation Fee	96,624	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,235,290	40
41	**Income before Income Taxes (line 30 minus line 40)****	(38,834)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (38,834)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,896	2,080	$ 59,850	$ 28.77	1
2	Assistant Director of Nursing	1,781	2,040	47,031	23.05	2
3	Registered Nurses	30,078	31,824	535,155	16.82	3
4	Licensed Practical Nurses	38,863	41,512	568,335	13.69	4
5	Nurse Aides & Orderlies	109,662	115,559	962,110	8.33	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,191	2,315	42,741	18.46	8
9	Activity Director	1,864	2,120	38,994	18.39	9
10	Activity Assistants	11,203	12,332	81,063	6.57	10
11	Social Service Workers	2,812	3,155	36,698	11.63	11
12	Dietician					12
13	Food Service Supervisor	2,121	2,209	37,432	16.95	13
14	Head Cook	4,649	4,835	46,589	9.64	14
15	Cook Helpers/Assistants	8,310	9,079	59,448	6.55	15
16	Dishwashers	26,432	27,326	143,569	5.25	16
17	Maintenance Workers	12,880	13,658	129,761	9.50	17
18	Housekeepers	21,495	22,624	138,298	6.11	18
19	Laundry	6,007	6,300	35,231	5.59	19
20	Administrator	1,560	2,161	72,252	33.43	20
21	Assistant Administrator	1,880	2,040	49,596	24.31	21
22	Other Administrative					22
23	Office Manager	1,896	2,120	28,488	13.44	23
24	Clerical	10,147	10,804	83,720	7.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,262	3,452	60,303	17.47	31
32	Other Health Care(specify)					32
33	Other(specify) Pastoral/Fundraisi	2,078	2,243	26,517	11.82	33
34	TOTAL (lines 1 - 33)	303,067	321,788	$ 3,283,181 *	$ 10.20	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	888	$ 39,955	L1C3	35
36	Medical Director	MTHLY	12,180	L9C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	2	67	L11C3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	890	$ 52,202		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	2,716	$ 121,422	L10C3	50
51	Licensed Practical Nurses	4,920	152,017	L10C3	51
52	Nurse Aides	29,050	535,672	L10C3	52
53	TOTAL (lines 50 - 52)	36,686	$ 809,111		53

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Cheryl Stout	Administrator	0	$ 72,252
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 72,252

B. Administrative - Other

Description	Amount
Management Fees	$ 505,300
TOTAL (agree to Schedule V, line 17, col. 3)	$ 505,300
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Barmann, Kramer & Bholen	legal fees	$ 1,328
Provena Health	MIS fees	14,064
Mission Resource Consult	Admin Consult	124
Brian Hill	Dietary Consult	37
Provena McAuley Manor	Admin Consult	9
TLN Partners	Admin Consult	680
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 16,242

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 122,419
Unemployment Compensation Insurance	2,300
FICA Taxes	240,769
Employee Health Insurance	249,491
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Dental Ins	25,972
Life Ins	15,609
Other	13,374
Pension	27,431
Disab Ins	11,561
Vision	6,384
Related Party	55,607
TOTAL (agree to Schedule V, line 22, col.8)	$ 770,917

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	16,078
Health Care Worker Background Check	840
(Indicate # of checks performed 120)	
Dues,Books, Subsc	9,124
Advertising	9,475
Less: Public Relations Expense	( )
Non-allowable advertising	(9,475)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 26,042

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,017
Seminar Expense	5,955
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,972

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Provena Villa Franciscan # 0042861 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Provena Villa Franciscan # 0042861 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network - $6,647**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **96,624**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Report being complied by KPMG**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.